Transcript of the CMMI CEC Model Learning Event
The ESRD Seamless Care Organization (ESCO) Experience
June 8, 2016

Jennifer: Hello, everyone, and thank you for joining us. I would like to welcome each of you to today's learning event titled the ESRD Seamless Care Organization Experience. My name is Jennifer Brock, and I'll be moderating today's learning event. During today's event, a panel of ESCO owners will share tips and recommendations for success, based on their experiences as model participants. There will be a twenty minute question and answer period following the panel. After the panel discussion, a CEC model team member will present what it takes to be a successful ESCO.

I would like to inform everyone on this call that all comments made on this call are offered only for general informational and educational purposes only. As always, the agency's positions on matters may be subject to change. CMS' comments are not offered as and do not constitute legal advice or legal opinions, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules, and regulations. ACOs are responsible for ensuring that their actions fully comply with applicable laws, rules, and regulations. We encourage you to consult with your own legal counsel to ensure such compliance.

Furthermore, the extent that we may seek to gather facts and information from you during this call, we intent to gather your individual input only. CMS is not seeking group advice. Before we get started, I would like to point out a few tips so we can have a successful learning event today. First, since we are recording this event, all attendee phone lines have been placed in a listen-only mode. The recording from today's event will be emailed to registered attendees following today's event. It can also be accessed by the Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model webpage within two weeks following the event.

Second, there will be two question and answer portions, one following the panelist discussion and one at the end of today's event. Attendees are encouraged to submit any questions they might have into the Q&A pod to the right of their webinar screen during the event or during the Q&A period. During the Q&A periods, we will attempt to address all questions entered into the pod to the model team. However, in the instance this is not possible, attendees are encouraged to email any questions not addressed to ESRD-CMMI@CMS.HHS.gov following this event.

If you have any technical questions or issues during today's event, please submit a question into the Q&A pod to Charles Glock, who is our producer. Charles will be happy to assist you. Additionally, a PDF copy of the slides for today's presentation, along with a copy of the RSA fact sheet can be accessed by clicking on the links under the download presentation pod, located to the right-hand of your screen. Lastly, we appreciate any feedback you have on today's event. A survey pod is available in the lower right corner of the screen. It is accessible to use throughout the event. The survey takes less than two minutes to complete and is anonymous. We look forward to your feedback during this call. Okay. Let's get started. I would like to begin by

conducting a brief poll to get a sense of the audience joining us today during the event. Charles, would you please open the poll?

Charles: Enter your responses, too. Just take a moment to click on the title that best describes you under question one, and click on the number of people currently in the room viewing today's event with you under question two. We'll just give you a minute more to complete the poll. Thanks.

Jennifer: All right. I think it looks like a majority of people have responded. We'll give it just thirty seconds more for folks to complete the poll. Thank you for everyone participating. All right, it looks like we have a very successful poll. It looks like we have a lot of dialysis facilities and a lot of people joining the webinar by their self. Let's move back into the room. Thank you to everyone for participating in the poll. All right, I would now like to turn this presentation over today to our speaker, Tom Duvall, who is the Operations Analyst at CMMI. Tom, the floor is yours.

Tom: Thanks, Jen. Welcome everybody to today's webinar. This is a follow-up to the webinar that we gave last Tuesday, which was in introduction to the CEC model and a little discussion about our solicitation. Hopefully you all attended that one. If you didn't, we're working on getting those slides and materials posted on our website, with our goal of getting that up by next week. For this webinar, we wanted to do something a little bit different. The last webinar was us really talking and sharing with you all some of the basics of the program, some of the basic policy nuances of the program.

For this webinar, we extended it a little. It's ninety minutes, and we're splitting it in two. The first part, which we're going to get to in a minute, is going to be some of our current ESCO participants coming from some different perspectives and talking about what their experience in the model has been like, and then opening that up for Q&A to really give you all an opportunity to ask some of the burning questions you may have about what it really means to participate in an ESCO. After that, we're going to have some words of wisdom from us here at CMS and really just some things that we want you all to think about as you're working through your applications and designing what your care model looks like and your ESCOs will look like, and then we'll have an open Q&A after that to clarify some of those.

We envision this as being a good way to really help you think and understand a lot more about what it really means to be an ESCO. With that ... Next slide. We have three guest speakers who I'd love to introduce, and if you all could kind of introduce yourselves in order, Lauren Stone Hollingsworth, Lisa Hobson, and Andrew Barba. If you all want to introduce yourselves and talk about your roles with you ESCOs ...

Lauren: Sure, I'll start. This is Lauren Hollingsworth. I am the Strategic Initiatives Officer at DCI. I had the opportunity to be involved with crafting our application to the initial RFA for the CEC model back a couple of years ago, so I've been involved with this effort since the beginning. I currently lead operations for our three ESCOs.

Jennifer: Lisa?

Lisa: Yeah. I'm Lisa Hobson. I am a nephrology nurse by trade, and I am the Dialysis Care Coordination Program Manager for all three of our ESCOs. My role is primarily to roll out the care coordinator programs in all of our ESCO markets, and then coach our care coordinators and the teams through the process to get to success.

Andrew: Great. Thanks, Lisa. This is Andrew Barba with DaVita. My primary role is to work with CMMI on a weekly basis to identify and resolve issues as we learn about them in implementing the ESCOs. I spend a lot of time internally with our operations team, trying to figure out how to innovate and put new pilots out into our model of care.

Tom: Great. Thank you all for being on. We have a few general questions that we're going to give to our panelists here. As a reminder to everyone in the audience, if you have any follow-up questions about anything that they're saying or any areas that you'd like for our panelists to talk about, please just enter your questions into the Q&A box. I think the first question is, what advice would you give to potential applicants? I think we can just answer questions in the same order as the introduction there.

Lauren: Sure. I guess the first bit of advice I would give, this is Lauren, is to reach out to potential participants early. Start those conversations early, because it takes time to really build your ESCO network, so to speak, to engage those partners, and start building your model of care. I would recommend getting started in that effort very early, and then just focusing, I guess, on the application effort. Assemble a talented team of subject matter experts. This is a lot for one person to take on by themselves, so I think having a talented team contribute to that effort is huge.

Staying really organized is also really important, because there are a lot of moving parts, probably I would say designating someone who can really lead the effort internally and manage the day. Like I said, there are a lot of moving parts. It helps to really have someone who's on first, so to speak. I guess one thing for the model of care, a huge thing that we have learned is to keep things simple, especially in the first performance year, to not try to take on too much. We're really building a new model of care here, and it's important to get down the basics first. Yeah. I'll pass it on to Lisa.

Lisa: Thanks, Lauren. From my perspective, when you're building your care coordination program, one of the big things I would recommend would be, when you're hiring people for your positions, is to hire for attitude. Most everybody who applies has the skillset you need, but it's that attitude of, "We can make a difference. We need to change. We want to change," and being very clear about the expectations at every level so that when you add partners or clinicians to your current program, that doesn't mean you're just putting that in there and that's going to fix everything. It's going to require change at every level in your organization, and you've got to have good leadership in place to understand that change. You also have to have a great support system in place as a sounding board for the frustrations when they come along, because yes, we all think this is fantastic, and we've got great ideas, but it's hard work.

If they don't think there's somebody there listening to their frustrations, who can help pull them out of that and keep them going, they will get frustrated and quit. To touch on one of the things that Lauren said, when you're reaching out to your partners, reach out to everybody. You will be really surprised who hears your message that says, "I want to be a part of that," because we certainly were, and it's been fantastic who has come out of the wood works to help us be successful. Lastly, I would just say communicate, communicate, communicate, because, like she said, there are so many moving parts. It's constantly changing. CMMI has made it very clear it's going to continue to change. The more communication you provide, the less frustration there is.

Andrew: Okay. I will add a few comments. I strongly agree with, I think, every one of those pieces of advice. Just to add to it would be, and Tom, correct me if I'm wrong here, but utilize CMMI as your resource. I think when we were really working to get things up and running, looking back, it would've been helpful to approach them more frequently, and in particular, to preview components of the application that we prepared with CMMI so you can minimize the back and forth, especially with the tight deadline coming up in July.

My second piece of advice is related to starting conversations with potential partners and nephrologists early. One very practical piece of advice that you maybe have already heard is, those participant lists that are due is part of the application. Encourage you to be as inclusive as you can. It's a non-binding list from which you can remove participants before the program starts. If you don't add them in at the beginning, you won't have an opportunity to add again until the second performance year.

Tom: Great. Thank you all. As a follow-up question to that, and coincidentally our question two, how have you really worked with some of the provider partners, especially the nephrologist, who we know are such an important part of this model as required owners, to really get them interested in working with you on your ESCOs. I think specifically, can you give examples of some of the types of partners who you've reached out to? That's a question made out from the audience. There's just a lot of interest about how you generally work with providers, and if you can even talk across the care spectrum, so specialists, physicians, facilities, hospitals, et cetera.

Lauren: Sure. This is Lauren. I'll start us off. We certainly focused our initial outreach effort with getting nephrologists on board since they are a key member, a required member of them all. While this is a new approach, a new model of care, there are many concerns that the nephrologists had. We really communicated the importance of this as a great opportunity to participate in building that new model of care. Rather than waiting for the change to come, there's an opportunity to actively participate in building that model. Nephrologists really responded well to that.

When we were talking with a nephrologist who was very skeptical of the model, we did reach out to CMMI or the CEC team to schedule conference calls with those

providers so that they could hear from Tom and the rest of the team the benefits of participating in the model. That made a tremendous impact on providers. We were really pleased with that. We also really tried to make the model as attractive as possible for those nephrologists providers by minimizing their risk for loss. Obviously, a tenet of this model is for the nephrologists to have been in the game, and that is really important. They don't have the resources that we have as a dialysis provider and other providers in the community. I think that relieved a lot of fears for the nephrologist.

Also, building innovative payment models with the nephrologists, that was a very attractive piece for them. We talked with them a lot about building a performance-based payment plan in which we would align cost and quality of care. Now, in addition to nephrologists, we also reached out to a local hospice provider, a palliative care provider, a home health agency, vascular access surgeons, a local ACO, who is not able to participate in the model, but is a partner in the model. We also have a regional health system. Lisa, are there any of them I'm leaving out?

Lisa: Hospice, palliative care, home health, surgeons. Any questions? Yeah, I'll pass it over to Andrew.

Andrew: Okay, great. Again, agree with those comments. It is a big concern. An individual nephrologist or a small group may have a tough time, but that is a critical part of the model. I thought about the question a little bit differently, which was, rather than how do you work to encourage certain nephrologists, you could also ask, "How do you identify nephrologists or nephrologist groups that will be strong partners in the model?" That is definitely something we looked at. A couple of things that we focused on, number one, the group is going to have more capability to partner and to invest in small practices.

That may be obvious, but it may be helpful to go to larger groups if you're finding that the solo practitioners are just not willing to take on the risk. Number two is assessing the market in which you apply, to the degree that you have a choice in markets or CBSAs, as is the case for ESCOs. It is important to start in a place where you have a better chance of succeeding. The ESCO's economic structure is such that the higher the baseline cost, potentially the more opportunity there is to reduce avoidable costs. We selected most of our ESCOs in part based on the cost baseline. I think partners will find it more attractive when you look at utilization for hospitals or you just look at the total non-dialysis costs. When that's a higher bar, there's a higher opportunity.

Lisa: This is Lisa. From a clinical standpoint, I would throw in there that data is very powerful. It's amazing how all of our - I won't say all - but most physicians think they're already doing everything they can possibly do for their patients, and they have the best outcomes they could possibly have. We did have the luxury here in the national market to start some care coordination before the ESCO actually started. We tried to identify who we thought would be ESCO patients. When we were able to pull out and show some of the success stories of when you take it a little further and the different things that you could do with your partners for your patients, and we were

able to show that it does make a difference in the outcomes, that kind of opened their eyes that there is more that we could be doing for our patients.

I think when you're working with them, providing the data, the trends, comparing the outcomes with other providers or other physicians in their practice, sharing those success stories and not giving up, not saying, "That's just all we can do for the patient," it's really pushing the envelope saying, "There is more that we can do."

Tom: Great. Just two quick follow-ups on that, and there will be more talk about engaging providers in the CMS section. One is, I think that Andrew and Lauren brought up some very good points there about really finding the providers that your patients are already seeing. Part of the point of an ESCO here is really creating a total care network for the patients, and that's easiest in looking at the providers who the patients are already seeing and building on existing referral networks where possible. I think the other thing, in response to a question that we got from the audience, the question was, "Do all partners have to be identified on the application?"

The terms that we're going to use here is that all participants have to be identified on the application. What that means is that all participants who you put down in the participant list section, those are the ones who are officially on your list. They're going to go through federal review. That enables them to get shared savings, to be part owners of the ESCO, and to use the waivers. If they're not going to do that, you can obviously still work with other providers. You can still refer to other providers, and patients are still free to see any providers who you want. Any providers, including at least the required nephrologist, who you want to potentially get shared savings, use the waivers or have any kind of ownership stake in the ESCO, those providers need to be on your list. Now, switching over to a care model question, what have been some of the biggest changes that you've made by being part of the CEC model, and how has your care model really changed the most from before the model started to now?

Lauren: This is Lauren. I'll say a few brief words, but I am not a clinician, and Lisa has really led this effort for us. I'll let her cover most of this. I would say we've really focused on changing the way we provide care for our patients by bringing additional support into our dialysis facilities through a care coordinator position. That has been a tremendous change, to incorporate a new member of the interdisciplinary care team and to really integrate that nurse into the staffing of our clinics.

We also have hired pharmacists who work very closely with our care coordinators and our patients on medication therapy management. We're really building a new care team. I would say that a huge change has been just integrating with other providers in the community. That was not something that we previously did. We really focused on care in our dialysis facilities and not outside of those walls. Increasing our communication and the level of coordination of care with those other providers has been a huge change and a huge effort. It's been so rewarding.

Lisa: Yeah. I'll just piggyback on that. The top things I thought of initially was the implementation of the role of the care coordinator, making the pharmacist a part of

the interdisciplinary team, not just having it as an additional resource, and really changing the entire collaboration of our IDT and the expectations of what the IDT's role is. We also have improved our documentations efforts and our reporting efforts. Starting the ESCO really made us go in and look at the current resources and tools we're using and realizing we had gaps for the care we were already providing, and then bigger gaps when we wanted to implement these changes.

We have definitely put resources in place to improve those. We've also increased our focus on communication outside of the dialysis unit, so rather than everything we're doing revolves around dialysis, it's everything else leads to dialysis, really. It's those relationships in the hospitals and all of our other providers that are touching our patients that can help us improve care. We're also using new resources, both with partners and with technology, so we're making sure that not only are we only doing more work, but we're being more efficient with our work and making sure that if we're asking people to do stuff, they have the resources to do them.

We've implemented care management pathways to try to prevent some of the - I call it 'crack-prevention'. When you're managing a lot of different things for a lot of different patients, it's really easy to forget where you left off, and so we're trying to put tools in place that put patients first. Lastly, I really think that we have changed our focus to a higher level of customer service to our patients and making the patient the center of our focus, rather than their treatment or their disease.

Andrew: I'll jump in just to try to add to it. A little bit of a different perspective, one of the things that we really tried to implement and develop after the dialysis bundle was implemented in 2011 was the idea of getting more towards quality and certainly away from just the focus on fee for service. We have this way of looking at how we deliver care that starts with the dialysis clinics and the fundamentals, things like managing … and hemoglobin, and calcium, and all of those things to into the next level, which is things like vascular access management, coordinating with vascular access centers like Lisa and Lauren mentioned. Then, the third level is really what we're trying to get to now with the ESCOs, which is reducing avoidable hospitalizations, preventing re-admissions, those layer of activities.

We've been, as an organization, trying to impact that third tier since 2011, but it's been really eye-opening to see how much and how little a lot of those programs truly affect patients being able to stay out of the hospital. For us, the big change is getting much more focused, and I think like Lauren said, really getting to the basics. What are those few critical things and activities that if you do them and you do them well will really help the patient and help them take a little bit more control over their course of care and some of the decisions that may lead to hospitalization. Bottom line there is it's been an eye-opener, and it's really helpful to be fully accountable for those results as a way to encourage innovation.

The only other thing I'll add is that DaVita has had some experience in other integrated care programs. We have a few small special needs plans that are run through the Medicare Advantage program. Traditionally, we've always hired nurses,

RNs. We are not trying to expand the care team, and we're looking at how we could utilize nurse practitioners to the top of their license to really further coordinate the care.

Tom: Great. Thank you all. I think the next question that we had that we were thinking about is, what surprised you, and I guess, what aspects have you modified from your original plan in starting up the ESCOs? So, questions four and five there, if you can talk about what's changed from your original expectations?

Lauren: Sure. This is Lauren. I would say something that has surprised us pleasantly is the level of collaboration with the CEC team. I don't think we anticipated how involved the CEC team would be, how much they would walk alongside us in this effort. That's been really, really tremendous. We've also really been surprised at the numerous learning opportunities within the CEC model, so being able to participate in ACO learning collaboratives, educational webinars, we really didn't anticipate those opportunities. That has been fantastic. I think another surprise, which maybe we shouldn't have been so surprised about, or I shouldn't have been so surprised about, is how much of a learning process operating an ESCO is. It is an evolving process, and we're learning day to day.

The next question, what would we change? I think that something that we want to focus on going forward is really advancing our level of integration with providers in the community. We had a great effort initially signing up participants when we applied back in 2014, but we really see the need to further integrate, so that's definitely something that we want to focus on more heavily. I think looking back retrospectively, if we could've had maybe a more structured, well-thought-out approach to rolling out some of these initiatives in our clinics, starting with engaging the clinic staff in this effort, the existing clinic staff, the four nurses, the patient care technicians, the dietitians, and social workers, that we would have benefited from that. They're such a huge part of this model. Lisa?

Lisa: Yeah, you're very accurate. I would say what has surprised me the most is how much the people who are excited about this ESCO are committed to the ESCO and the processes, and that they are willing to do whatever it takes. They really want this change. I'm actually hosting all three ESCOs care coordinators in our corporate office this week, and the enthusiasm in that room is just blowing me away. I expected it to be a 'complain fest', and they are just great! They want to know what else they can do, how else can they make it better, so it is fascinating. I think what's also been very eye-opening to our processes. As we've trained more root cause analysis and really had the owners dig, that they're finding out that what they thought were their biggest problems in their areas aren't their biggest problems, and maybe fluid overload isn't the number one reason for hospitalizations, and that maybe we've had the wrong focus in the past.

We're able to attack those things from a different perspective now. I'm also very surprised how willing our partners have been to help us and how much they want our patients to succeed. They have really opened our eyes. It's amazing how many times

we've collaborated and talked. When they tell us what they did for our patients, everyone in the room is like, "Oh duh. Why didn't we think of that? We should've done that a long time ago." It's shocking how much we don't know. It's been so fun learning from all of our partners and opening our eyes to those things.

As far as things that I would change if we could do it differently, is probably promise less in the beginning. We're all very excited, and we want it to be fantastic. It was really easy to get wrapped up in that, so in the beginning, like Lauren said, if you start with the basics and slowly integrate it, you probably have a little less frustration. I think it would've been helpful at the corporate level to have a few more support people. We had a small team trying to do a lot, and it was a lot. Now I think we're moving toward that differently.

I would also encourage you to trust your clinicians. They have been working with these patients for a really long time, and they have insight that makes it very valuable in some of the pathways that we put in place. Lastly, probably more physician-to-physician communication and keeping the physicians at the top of the communication chain, because they're the ones that ultimately oversee everything that's going on with the patients, and they need to know what changes are taking place so that they can be a part of that and not be surprised by that.

Andrew: Okay. Thanks, Lisa. Let me offer a different perspective. Agree with a lot there. I think I would've chose some surprises about what matters and what matters less. That was helpful. To touch on more corporate support, I just wanted to offer a few comments. One of the things that we were surprised about last year when we were preparing the application was just how much work we would have to go through even to get a successful application cleared internally before it goes to CMS. Our experience was could have used a lot more legal resources, could have started our discussions with potential partner nephrologists earlier, as I mentioned before.

As for what has surprised us a little bit early on and that we're getting a growing comfort with is the fact that the financial estimates do change, and there is a lot of math and thoughtfulness that goes into the shared savings calculation, but it can be difficult when the numbers change, and you have to explain that to your partners and to whoever you report to in your organization. Just something to be mindful of, to set expectations early within your organization. The other thing I would say to the second question, which is what might get changed now that we've had some experience running ESCOs, I do think it's too early to tell, even though we've been in it for eight months, but there are a few things that I think will be true in a couple of months.

I mentioned piloting efforts, and in order to pilot a new project for our organization, we go through very rigorous legal reviews for anti-kick-back statutes, stark law, and patient inducement, all laws that are really important in a fee for service world but maybe outdated in an integrated care world that we're all trying to move to. As a result, we need a lot of legal review and carefully structured proposals to pilot just about anything. If I could change one thing, I would have put in for more legal support

in our budget. I do think that it would help speed the pace of innovation in our organization.

Tom: Great. Thank you all there for your different perspectives. Before we get to the last question, we had a question from the audience that I think is a good one for discussion. The question was, what about involvement in patient mentor organizations? Could you talk a little more broadly about how you've engaged patients and created personalized models of care? There's been a lot of discussion on provider engagement, but if you all could talk about patient engagement ...

Lisa: This is Lisa. I'll talk about that a little bit. We have definitely realized that this is new to the patient. They didn't pick to be in the ESCO. They just all of a sudden were a dialysis patient, and now they are an ESCO beneficiary, and there's a lot of things being thrown at them that they don't understand. One thing that we have talked about is having a packet for the care coordinators to share with the patients, to let them know why they're in the ESCO in the first place, what that means to them, what it's going to look like, what additional resources are going to be available to them, making sure they have the care coordinators contact information so that they start to build that relationship right off the bat, that the care coordinator's the center of all of the resources that are available to them.

We are also participating with a technology base, a company called RoundingWell, that allows patients to sign up for a service that gives them ... It's a web-based platform that sends them periodic check-ins, so they're able to answer questions about their own healthcare. Some of it is dialysis-related. Some of it is not, but they can do it in the privacy of their own home whenever they want to, and how they answer questions gets sent back to the care coordinator as feedback and lets them know, "Hey, your patient might have an issue with this. You should follow up on that." We are giving the patients the opportunity to participate in that. That's primarily it. We're also including the patient in the IDT meetings in some cases and soliciting their feedback. The pathways that we've created for the care coordinators, it's frequent follow-up with the patients. We've started implementing more depression screenings, anxiety screenings, patient activation measure screenings, so that we were really addressing the patient where the patient has a need.

Tom: Great. Thank you, Lisa. Anything to add there, Andrew or Lauren?

Andrew: This is Andrew. Not a whole lot to add, but one thing we do try to do, and our model is a little bit different, we have ... Well, I think it may be different. We have the dialysis clinic teammates, and that continues in to ESCO clinics. On top of that, we have nurses, care coordinators, and nurse practitioners that, for lack of a better word, round regularly at the clinics. One of the things that we really try to focus on with the patient that's non-clinical is goal-setting. We look at it very broadly, but what we try to make sure we do is, whatever the goal is that the patients wants to achieve, to put a date on it that they set, and to check in on that goal on a regular basis.

The main thing we're focusing on there is to try to get patients who may feel overwhelmed, which may be many patients who are new to dialysis, to help them realize that most of the things that they're going to have to deal with can be broken down into small pieces. If you can just start chipping away at pieces over time, we believe that the patient will be more empowered and will be a healthier patient. That's one area that we really try to focus on.

Lauren: This is Lauren. I'll just add one thing. One thing we've been focusing on with patient engagement to engage these kidney disease patients and their care prior to reaching dialysis. We have a chronic kidney disease education and care coordination program in each of our ESCO markets. Our staff there, our nurse staff, are working with patients to engage them in their care, prepare them for that transition to dialysis if it occurs, educating them on their options for care. If we can reach patients earlier and engage them earlier, then if they do progress to end stage renal disease and choose dialysis as their choice of therapy, then that patient enters the dialysis clinic an engaged patient.

Tom: Great. Thank you all. I think we have one final question. As always, audience, let us know if you have any other questions for our panelists, and put it into the box. We'll cover some of the program-related questions in a little bit, but if you have any questions for the panelists about their ESCO experience, just let us know. I think the final question here is, what makes you most proud about being a part of this model, and what's the success that you've had?

Lauren: This is Lauren. I'll start us off. First of all, I'll just say that we are proud to be a part of this model. We have really enjoyed participating in the model and are looking forward to participating going forward. Something that we're really proud of, or that I am really proud of it the people we have on board. We have really focused on bringing the right team members on board to build this effort and to execute this effort. That's from staff in our clinic to our care coordinators, our pharmacists, our clinical managers. We have a really talented and engaged team of people. Also, our partnerships, we're really proud of the partnerships we've built in the communities where we have ESCOs. It's just been a tremendous positive change and is allowing us to provide a much higher level of care to our patients, and then just speaking to our staff.

They're so important. They're such an important part of this model. They really are the crux of it, and they've been really adaptable in this effort. I think it's so important to have adaptable staff because this is an evolving model. If you're hiring stuff who are looking for a static role, being a part of the ESCO is not that. Yeah, I think we're just as a whole really proud of the people we have on board. Lisa spoke to this earlier, but just some of the technology that we've been able to deploy to not only our staff but our patients, and just getting them the resources they need to engage patients in their care, to make providing care to patients and managing care a more seamless effort.

Lisa: Yeah, it's hard to top that, however, I will just add to that. One of the things that I'm proud of is the ownership that my team has taken to make the lives of our patients better. I've been listening to these comments all week, and when I hear comments like, "This is the job that I have always wanted, because I'm finally getting to do the things I've always wanted to do with my patients, and I've never had the time." I heard another nurse who has an acute background say, "People are finally listening to us." Our patients need more, and we now have the ability to implement those changes and make a difference in their lives.

From a DCI standpoint, I think what I'm proud of is the fact that we're able to change our focus to not just provide good dialysis but to prevent dialysis in the first place if we can, and then for those patients who need it or choose it, help them transition to the end of life with dignity, and pride, and somebody holding their hand, with an angel by their side, as one of our patients has told us. When you see the opportunities we have besides just providing dialysis, it's fascinating, and it's really helping us evolve into a kidney care partner or a kidney care provider, instead of just a dialysis provider. That's very powerful.

Andrew: Those are excellent examples. I think my experience of being an ESCO is similar. We are incredibly proud to be part of integrated care, to have a seat at the table. We are really, really proud about some of the stories we heard so far about examples where things happened for the benefit of the patient that would be very hard to imagine happening outside of an integrated care model. I just want to take a moment to tell a story that Lisa and Lauren, you probably have several examples of already, but we had a patient in our south Florida ESCO who came in on a Tuesday for her dialysis and learned that the axis wasn't working. That's already a few days without dialysis. He charged her and decided to send her home, and asked her to visit a vascular access center the next day if possible.

That would've been the default, and hopefully you get the dialysis on Wednesday, but maybe not until Thursday, and then you've got some real issues. Maybe fluid overload gets too bad that they have to go to the hospital. Instead what happened was our care coordinator picked up the phone, called the interventional radiologist at the nearby ... Sorry, interventional nephrologist at the nearby vascular access center to present the case, and it just so happened that there was availability to get the procedure done that afternoon.

The care coordinator went back to the patient's nephrologist, went back to the clinic's charge nurse to present the situation and the solution, and they were all in agreement. They were able to get that procedure done and even get our patient back to get their dialysis the same day. That, to me, is just a nice practical, simple example of ... Like Lisa and Lauren said, when you have more time, it is your job to make sure that patient gets the care that they need. Things like this are possible.

Tom: Great. Thank you all very much. One question that we had in from the audience, and this is going to be our last question for the panel. How have you dealt with patients who, I guess, want to be treated by a provider who's not your partner or participant,

and how have you dealt with that issue, whether they have a different nephrologist or just a different care pattern?

Lisa: This is Lisa. We haven't had a lot of push-back as of yet. We do absolutely provide choice to the patients. I would say maybe from our partners' standpoint, we've got ... Depending on geography, maybe our partner doesn't provide a service in that market, so we do give them a list, just like we would any other patient, and encourage them to use them. If we do have multiple options in the market, and one is our provider and one is not, we let them know what successes we've had with the partner, but we do still allow them to make the choice. I can't say that we have had a lot of push-back. I think the patients learn to trust their clinicians. We can explain to them why we picked them as a partner in the first place and let them know that we wouldn't have picked them if we didn't think they were good partners. I think they trust our judgement, and they tend to want to use who we want them to use.

Jennifer: All right, thank you, panelists. I'm actually going to step in here, because we're about to close the panel at this time. Thank you to everyone, of the panelists for participating, and thank you for everyone who entered questions. We do apologize in advance if your questions were not able to be asked during this session. Feel free to please email ESRD-CMMI@CMS.HHS.gov with your questions that were not addressed, and the team will get back to you with a response. I will now turn the presentation back over to Tom Duvall, who will present what it takes to be a successful ESCO. Tom?

Tom: Thanks. We put together a few slides. Some of it follows up on what some of our participants were talking about, but some of it just also addresses some things that we've seen from the CMS side that we really want you all to think about, just some key emphases to think about informing your structure and your focus areas. After this, we'll be open for questions and go through some of the questions that we had before. As our panelists, the first and most important part of the ESCO is the provider network. Ultimately, as an ESCO, you're responsible for coordinating across the full spectrum of Medicare care, so all of the ANB services for these patients.

The most critical part of that is the nephrologist. They're accountable for downside losses in a two-sided model. One thing that we wanted you all to think about is that the beneficiaries are aligned through dialysis facilities and not the nephrologists. There's obviously a correlation between the patients who visit a dialysis facility and those who may visit a specific nephrologist, but alignment is done through the dialysis facility. When you're building your networks, try to think about the nephrologists who are seeing the majority of patients in your facilities. That's just something important for you to think about in trying to create the coordinated care network based off of the doctors that the patients are already really seeing.

There was also a question we'd gotten and something Andrew had brought up about minimizing risk. Nephrologists are required to be participant owners. You ESCOs are required to have at least one. Each nephrologist in a two-sided model is required to be at a certain percentage of downside risk, meaning that if the ESCO as a whole has

losses and has to pay money back to CMS, the nephrologist personally has to pay money back to CMS. It's a relatively small portion, because it's based off of 50% of their revenue for ESCO patients divided by the total revenue for ESCO patients, but it is sort of a required minimum for some of the nephrologists.

I think the other thing that we wanted to talk about with just provider networks is that ESCOs aren't required to include specialists, but you're very encouraged to consider those relationships. They're an important part of the care delivery process, pretty obviously. Part of the way that we measure this program and the effects of the ESCO is through our quality reporting. Some of our quality measures require data from outpatient providers visited by ESCO beneficiaries. This is not saying that all these specialists and other types of providers need to be on your participant list, but that you should try to form a relationship with all of the doctors who your patients are going to go see. This is something that when you get the full claims data, you'll be able to see all of the physicians and specialists who are visited by your patients.

Continuing on that and in a similar vein, hospitals. As you all know, hospitals are a very big cost center and just a very big important source of care for ESRD patients, with on average of two hospitalizations per year per patient. There's also a lot of different quality measures in the model based around patient hospitalizations. Again, this may be a slightly difficult relationship to form, but it's worth looking at and thinking about in your ESCO, how can we at least reach out and form a relationship with the key hospitals, with the hospitals that our patients are seeing. How can we then work with them on issues like discharge planning, on letting the ESCO know if the patient goes to the hospital, on care transitions, some of the areas that you'll be able to most easily attack to really help improve beneficiary care.

Another issue is just you need to think about how to keep providers in your network engaged in an ongoing process. There's obviously this initial flurry of sign up and then getting them to sign official agreements, but this is an ongoing process, as some of our panelists were talking about, about keeping them engaged, keeping them part of the care process, and really keeping them up on all the various parts of the model. It's worth thinking about what internal communication plans would look like. The next thing then is, and we'll cover this in future webinars, too, but the providers don't need to be signed by July 15th, however, you need to include any potentially interested ESCO participants in your application.

What this means just to ... This is something I know we've gone over multiple times, but this is a pretty big deal. The way that this works is that you all will send in your application July 15th. We're going to take that list of providers and run it through the federal review process to make sure that there's no significant red flags with any of them. Once that is complete, and if you've been accepted, then we'll give you back the final vetted list of providers, and you all will sign and verify that you have agreements with all of them. You don't have to have agreements with everybody by July 15th, but you can't have an agreement with somebody unless they were on the July 15th list.

It means that it's worth including and thinking through any provider who you want to potentially be a part of the ESCO and seeing if you then be able to get them to sign by December, when you'd have to officially verify that you have agreements with these providers. I think the other thing, then, too, it may seem a little bit contradictory, but it's just remembering that the ESCO is a process. You're not going to come in with it. As our panelists showed, there is networks and everything has already evolved over the time of the model. You can start with a more limited network as long as you have at least one nephrologist. Think about who you want to add for year three, year four of the model, and I guess try to build your network over time. It's important to start with the most easily doable areas and the most easily get-able providers, and then work to expand your reach.

Now, getting into a little bit just about what the ESCO process actually means. One is just, we at CMS will be doing a lot of talking with you. This will come through a lot of different methods. One is, we do a weekly executive call with leaders from all of the ESCOs in the model. This is a time for CMS and ESCOs to talk about any new policies, any new operational issues, and to go over issues affecting every ESCO in the model. We also do calls with individual project officers to go over the specific needs of your ESCO to try to be as responding as possible. We also use the inbox to respond to any inquiries that happen and to route things to the proper team members.

We have a learning system to really help assist ESCOs with quality improvement, and we do an annual face to face meeting with all of the ESCOs and then also with the pioneer ACOs and the next generation ACOs that are in other CMS programs. We really do try to reach out to you, and talk to you, and understand how you're doing, and try to deal with any issues you all are having. We also share a good amount of financial and other data. We send you alignment reports that show who the aligned beneficiaries are. We'll send you monthly, quarterly, and annual financial reports to show how you're doing relative to your benchmark. We're going to have a dashboard that's going to show utilization data and allow you to compare how you're doing relative to other ESCOs, as well as sending detailed Medicare ANB claims data for all beneficiaries and D, actually, which is going to get you a wealth of data about your beneficiary's total health needs that you may not necessarily be used to.

With that data and with what the duties of the ESCO are, we just wanted to bring up some of the key people who we've seen that ESCOs really need in order to, we think, get the most out of the model. There's just some kind of coordinating with CMS and dealing with the stuff that we give you. One is just a liaison to talk with us about project officer and weekly calls with the ESCOs. There's also a quality reporting burden. You need to think about who in your organization would be responsible for identifying all of the relative quality data, staff to coordinate with providers, and to ensure that all of your providers are happy and remain part of your networks.

Legal staff, as Andrew said, there is a lot of legal work, especially at the beginning and in the application phase with the model, so it's important to understand the participation agreement, the waivers, and the other legal documents shared by CMS. Finally, data analytics staff. We're going to meet to analyze the claims data, financial

data, and alignment data. This is going to be a very significant data set that we're going to be giving you, that'll definitely go beyond existing excel-based knowledge. In order to, I think, really get the most out of the model, we think that having a separate staff identified to analyze claims data will be important. Other key staff is representatives from the company, and we'll talk about that in a minute.

Now, we just have a few slides of more random lessons that we just really wanted to share with you and for you all to think about. One of them is noting the differences between the ESCO and the company. This gets a little bit complicated, but it relates back to the structure of the model. The idea is that the ESCO is that independent new corporate entity that is formed for the purpose of participating in this model. The ESCO is owned by its participant owners, which consist of the dialysis facilities, nephrologists, and any other participants who you wish to have in the model as owners.

The key is that the ownership is done by the individual dialysis company, by the individual dialysis units, and the individual nephrologists participating in the model. That means that it is owned by the specific facilities and not the larger corporate entity that owns the dialysis facility, and plays a key role described in the waivers. That would be the company which is that corporate entity. That's the key distinction to think about. In the application, we explicitly ask for different contacts from the company versus the ESCO. It's important to understand that difference there.

Another big just general principle, ESCOs are coordinated care, but there's some very important differences between that and managed care. One is that there's no set benchmark at the start of the year. We'll get into this in a little bit, but the final benchmark, because we need the most accurate risk and trend information, will not be known until after the year. We'll work and give you some data to help you estimate it, but the final benchmark, and the final cost target, and the final how you're doing, we're not going to know until after the year, because we want to make sure that we have the most accurate data possible.

Another thing is that beneficiaries just get full freedom of choice. It's the bedrock of Medicare fee for service, so they can see any physicians who they want to see. This got brought up in one of the questions that we put to the panel, but part of your job is, within the fee for service infrastructure of building a network that can really support all of the ESCOs, and finally just that some of the managed care techniques that have been used in the past may not necessarily work. I think another thing is that just bringing in your governing board, that's a key part of the ESCO governance process, and it's just important to bring them in early and often to ensure that they're included in major decisions. This is just something that we found, that that can be a key choke-point in the process, so bringing them in and making sure they're as engaged as possible would be important.

Next is just creating a clear organizational structure and identifying who your key staff are. This is part of the application process, but it's also an ongoing process that'll take place between now and January 1st to really help figure out who all of your staff are

going to be and who's going to fill all of the roles that we talked about on the previous slide. Another one is just talking about the data quality reporting lead. There's a lot of data floating around in this model, both that CMS will give you and that you all will have to report back to CMS about how you performed on certain quality measures. It's important to think about gathering that early, forming the relationships with providers, and figuring out who in your organization is going to be responsible for this.

Another thing is just having realistic expectations in year one. You're not going to be able to implement your full care interventions all at once, and it's going to be a process over the entire time of the model. It's worth triaging your interventions and thinking about what's the most important to do at the beginning. A few more key lessons here, we'll share the best data that we have, the best claims data, the best financial data, but it's not going to be real time, and the final financial data, the definitive data, will not be available until after the year. Again, we're going to share it in ways with which you may not be as familiar, and which is definitely going to require some specialized skill to analyze.

Another issue just in general is that the alignment algorithm that we use for the model and is fully laid out in the RFA means that not all of the patients who walk into your dialysis clinics will be aligned to your ESCO. They might be aligned to other CMS programs. They may not have their full Medicare ANB coverage and may be in the transition period. There's some potential issues there. It's worth thinking about as you're planning and thinking about your numbers and to hit the three hundred fifty minimum for LDOs or below that for non-LDOs. All the patients who walk into your clinic are not going to be part of your ESCO.

Two other things just about the application process and in general. One is to send in your application information as soon as possible. This is just something just to get started in getting access to the system and really making sure that you have what you need with plenty of time to work on the application. We'll contact you if we have any questions and it looks like you may have put multiple ESCOs in the same market, just to make sure that that was what you intended.

The final, maybe most important thing is that we're very willing to work with you just to answer any questions you have and really just willing to work with you as part of the model. We're all very interested and invested in your success. We can set the policies the way we want, but it's ultimately based on your experience on the ground and your hard work on the ground to really help improve what's a lot for patients. Next slide. Finally, just a few care transformation points, because it's not just this operational part here. It's emphasizing some of the things from before, but you don't have to implement your care model all at once. Prioritize, add additional providers year over year.

The hospital relationships, though, are some of the critical ones our ESCOs have found in PY1 to help identify admissions and re-admissions and help really attack a big cost center. We have a learning system that can really work to help identify the strategies

that have worked for others and to share with all of you participating in the model. Finally, it works the best when we have just an open sharing of successes and lessons learned so we can all really learn together, and this whole model is based on a pretty collaborative approach that we're very excited for.

Jennifer: Thank you, Tom. Great presentation. I'd now like to open the second question and answer portion of our event. I will read questions entered into the Q&A pod in order that they are received. Any questions not addressed by the panel today or model team, may be emailed following today's event to ESRD-CMMI@CMS.HHS.gov for response. Again, I do apologize in advance if your question is not able to be asked during today's event. All right, I'm going to turn over to the Q&A pod. We have a big set of questions here to go. I'm going to start with the first one. Will the standardized re-admission ratio be calculated the same as it is in the QIP? Currently, it is indicated as claims and CMS administrative data. Tom?

Tom: Sure. I'm going to pass you off Sid Mazumdar, who works on it in that quality measure for our team.

Sid: We're still developing the standardized re-admissions ratio. We expect that it will be calculated the same way as the QIP, but this is not final yet. We know the issues between the different ways it could be calculated. Expect further guidance from us on this.

Jennifer: Okay. Next question, how much push-back have you received from patients who wish to be treated by a provider that is not your partner/participant?

Tom: This is an issue that we talked about while with the panel, and I think this is something that we've seen some of, but we think that with the larger issue of just forming the networks with the physicians that your ESCO patients are already seeing, we think that that's a solvable problem.

Jennifer: Okay. How would you minimize risk for physician partners?

Tom: Sure. There's multiple things going on here. One is that we do require all participant owners, which includes the nephrologists, to have the minimum downside risk. However, that minimum is set based off of a formula that's in the RFA document and says that they are only responsible for 50% of their proportion of total ESCO revenue, which considering that they're a nephrologist relative to the amount of funds spent in the dialysis clinic or in the hospitals, it's a relatively small share of any potential losses. For non-LDOs, you could be in the one-model that has no downside risk for physicians.

Finally, for those in the two-sided model, on both the LDO and non-LDO side, you have the option to increase your minimum savings and loss rate. What this means is, that's the CMS margin of error that we talked about that's in the calculations. It's set at 1%, meaning that savings or losses would have to be greater than 1% of the cost target in order to be paid out. You could increase that up to 2%, which cuts down on

the potential upside but also definitely cuts down on the potential downside, and means that it's a lesser chance of paying savings back to CMS. I'd also add it's worth looking at the waiver documents very closely to look at some of the capital funding that's required for the ESCO and to see what the company can put in, the dialysis company, versus other participant owners.

Jennifer: Thanks, Tom. Next question, should care coordinators all be RNs?

Tom: I think this is an issue ... Short answer on this is no. I think longer answer on this is that we think this is something important for you to think about. Think about how you want, due to the functions, that you want your care coordinators to perform and the task that you want them to do, and think about if you need RNs, if you need social workers, if you need nurse practitioners, and think through all of the different social and medical needs that patients have when thinking about who your care coordinators could be.

Jennifer: Great. Next question was entered when we were talking about the application a few slides back. Pertaining to the application, what is considered to be a significant red flag?

Tom: I'm going to pass this off to Emma Oppenheim on our team, who's been assisting on the applications.

Emma: I think regarding the applications, very significant red flags are if you do not answer a question, if you fail to follow directions, things like that that would make your application be incomplete.

Tom: Yeah. In our next webinar next Thursday, not to step on coming attractions here, we're going to go over the application in detail, go over how to really use the module, and also talk about what CMS is really looking for with some of the questions to help you really guide your answers.

Jennifer: Thanks, Tom. Next one may have been already addressed, but I'm just going to ask it. Are the ESRD patients going to be prioritized from an ACO into the ESCO?

Tom: Short answer is yes. Longer answer is, we worked out a complicated series of arrangements with the other ACO models. At the beginning of the year, we have priority over every other ACO model for an ESRD, so they would go into your ESCO at the start of the year. During the year, if a patient's already part of an SSP Track 3 Pioneer or a next generation ACO, they would stay in that ACO, but then at the end of the year, they could transition over to an ESCO. However, if they're part of an SSP Track 1 or Track 2 ACO, which is something like 80% plus of ACOs around the country and the vast majority of ACO patients you see, they would be immediately eligible to join your ESCO.

Jennifer: Great. Next question, can physicians participate using multiple tax IDs and NPIs? Will their revenue be added together, then divided by total revenue to get their percentage of downside risk?

Tom: We identify physicians through their 10 MPI combination. It means that each individual provider has one 10 MPI combination, and this is again making sure that that 10 is not part of another ACO program. I hope that makes sense.

Jennifer: The 10 can't be part of SSP? There definitely actually are scenarios in which we have 10s participating in our model that are participating in other models. What's important is that you're using a unique 10 MPI for each participant.

Tom: There are, I think, a few other questions that had come up earlier that we wanted to address. One of the questions was, is the number of Medicare patients still at three-fifty? That's the required minimum for LDOs. For non-LDOs, you are not required to be at three-fifty, but you are required to be at ... If you are under three-fifty, then you are required to aggregate and join in an aggregation pool. One thing to remember when thinking about the number of patients is to think about what some of our requirements are. It means that you're Medicare fee for service, so it excludes Medicare Advantage. You have to have full ANB coverage, which means you can't be during the transition period.

You can't have Medicare as a secondary payer, some kind of private insurance. You have to be over eighteen, and a few other ones, but those are some of the big ones that really help, and not in any other CMS programs. This means that any patients, that is really going to be a subset of the patients who walk into your clinic. Another question we had is, do we really have to include all of the patients in the model? By this, I just wanted to just go over alignment a little bit.

Again, this is a sneak peek of webinar number four, which is going to be a much more detailed look about the alignment, financial, and quality methodologies to really help you think about how those are going to work. In general, the way that the alignment algorithm works is that we assign to your ESCO the patients who are eligible, who'll have a dialysis visit at your an ESCO dialysis facility, because we see that those are the patients who you're treating, and even if they have one visit, then they are aligned to your ESCO for at least the rest of the year. Your patients are aligned on the CMS side, and ESCOs or dialysis facilities wouldn't tell us who they want aligned.

We also got another question about, what is the sharing model between dialysis facilities and nephrologists? This is an interesting question because CMS doesn't prescribe that many rules around this. We require that nephrologists are participant owners, but we view part of this process as coming up with what a good business model is, to share between dialysis facilities, nephrologists, as well as hospitals and some of the other key providers who are ultimately going to be brought in. This is something that we think is very important. It's somewhat up to you all to think about how you're going to do it and outlined for us in the application. There is the required

minimum for shared losses for nephrologists, and the ESCO as a whole is responsible for all of the losses.

Jennifer: Thanks, Tom. We have a couple of other questions at the top. What is the sharing model between dialysis units and nephrologists for gains and losses? I know that was talked about a little bit.

Tom: Yes, that was what I just went through, and it's ultimately that every participant owner has a required minimum portion of the losses, but the losses as a whole must be paid for in total by the ESCO.

Jennifer: What about involvement in patient mentor organizations?

Tom: Yeah, that was one that we talked about with patient engagement with the panel. I think we encourage you reaching out to any kind of patient organization, other providers. Social resources are a very important part of the model. They wouldn't officially be participants and getting shared savings, because only Medicare-enrolled providers can. I think reaching out to them and social services is an important part of dealing with the patient's whole set of needs.

Jennifer: How involved are the individual nephrologists in changing behaviors in the model of care?

Tom: On this question, the short answer is, they are really put at the center of everything. Our goal is that the nephrologists work in concert with the dialysis facilities, and really serve as the primary care physician for these patients, coordinating across all of the ESRDs patient's other doctors, and really just being responsible for everything across the entire spectrum of care, working with the hospitals, coordinating the work of the care coordinators, and really just serving as the overseer of the patient's entire care needs.

Jennifer: Great. Does a higher cost facility equal more hospitalizations?

Tom: Not necessarily. I'll separate a few different things about what high cost means here. One is the cost of the bundle, the ESRD, PPS bundle, how you all are paid for dialysis services. On this, we standardized the cost of the bundle and just used the base rate in our financial calculations. It won't affect your payment, but it means that a dialysis facility with a higher bundle wouldn't be penalized, or you couldn't save money by switching from a dialysis facility with a higher cost bundle to one with a lower cost bundle and PTS payment. In another sense, talking about a higher cost region, in general the greater number.

An ESCO is measured against what its performance would've been in 2012, '13, and '14. If there's a lot of need in the community, and the patients in your community are sicker, for whatever reason, then that means that there's more opportunity to really help drive down costs. In that case then, some of the areas where there may be procedures that don't have as much medical value being done or patients who are

really in need of care coordination, then there's a definitely opportunity there. I'd also add that we use risk adjustment to really help correct it so that you're not penalized for the patient population being sicker in one year versus another.

Jennifer: Great. We've covered all of the questions that have been entered into the Q&A pod. If I may have accidentally skipped your question or if you have an additional question, please feel free to enter that now into the Q&A pod at the top right of your screen. I'm just going to pause for thirty seconds.

Tom: Great. While you're paused, I just want to especially thank our participants from DaVita and DCI. We'd even brought it to all of our participants, and we just grabbed those two as a representative sample there.

Jennifer: We have one more question added in. In relation to the tax ID, we have some docs and two tax IDs with NPIs. Is this okay? Both nephrology-related.

Tom: Okay. In this scenario, there's a physician who may be participating and who may be a part of two different practices. They have one NPI and then they bill under two different 10s. In that case then, they would pick which combination. They would only pick of the one of the 10 MPI combinations to put into the model.

Lauren: We understand that it's common to have multiple doctors having different 10s, in particular, billing under different 10s. Yes, we're used to that, and we expect that.

Jennifer: Great. Last question, how are ESCOs initially funded?

Tom: This is another issue where we've issued some legal guidance on this, and this is heavily addressed in the waivers, the waiver documents that is linked. Ultimately, the funding comes from some combination of the ESCO participants and the company. I think it's worth reading those documents to think about how you want to best come up with the capital to support the ESCO organization and fund the care coordination technology, staff, et cetera, that's needed. Ultimately, that's something that's going to have to be your individual business decision that fits within the parameters set up by CMS. CMS doesn't offer any kind of initial funding stream.

Jennifer: Great. That's all the questions that we have for today. I would like to now formally close the Q&A portion of today's event. Once again, we want to remind you that all applications much be received by July 15th. All right. Participants are encouraged to review the posted RSA, and we want to be sure that all participants are aware of the additional resources available. You can also download the RFA fact sheet, which is located on the bottom right-hand portion of the screen. Tom, I'm going to turn this back over to you to do closing remarks, and then I'll wrap up with the feedback survey.

Tom: Yeah. We just want to thank you all and just remind you all about these additional resources here. As always, email the inbox if you have any questions. As it on one of

these webinars. We'll follow up with what our future webinars are. Thank you all for your interest here in CEC and the RFA process.

Jennifer: Fantastic. Upcoming learning events are listed on the screen. Please attend if you're able and interested. There will be opportunities to participate in additional Q&A during these events. We also have the upcoming office hours on July 6th, 12th, and 14th. These are opportunities for you to dial in to a private conversation and ask specific questions about the application and receive any support regarding completing your application, as well as technical support. The links for these webinars and office hour events will be emailed out to you at the email used to register for this webinar. All right, please attend.

If you have any questions pertaining to this, feel free to submit them to ESRD-CMMI@HHS.CMS.gov. Before I close today's event, we'd like to ask for your help by completing a quick survey. We are always trying to improve our learning events, and your feedback will help us do this. We'd really appreciate it if everyone would take a minute or two to provide us with feedback pertaining to today's event. To complete the survey, please look in the lower center right of the webinar screen for the post-event survey pod. Please click on the link in the pod and select "browse to" to access our survey. All right, while you're taking the survey, I would like to thank our panelists once again for participating in our event today, and also Tom, our fantastic presenter. Please visit the CEC model website to access these resources we talked about. We look forward to seeing you in our future events. I'm formally going to close the webinar for today. I hope everyone has a fantastic day. Thank you so much, everyone.